HC-One Limited

Orchard Mews

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This was an unannounced inspection carried out on 26 August 2015.

We last inspected Orchard Mews in April 2014. At that inspection we found the service was meeting all legal requirements in force at the time.

Orchard Mews is a 36 bed care home that provides personal and nursing care to older people, including people who live with dementia or a dementia related condition.

A registered manager was not in post but a relief manager had applied to be registered with the Care Quality Commission in July 2015. They were running the service until the new manager started in October. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

People said they were safe and staff were kind and approachable. We had concerns however there were not enough staff on duty to provide safe and individual care to people.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Systems were in place for people to receive their medicines in a safe way.

People had access to health care professionals to make sure they received appropriate care and treatment.

Orchard Mews was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet to meet their nutritional needs. However people who lived with dementia were not all encouraged to make choices with regard to their food.

People who lived with dementia were not encouraged to remain involved with their surroundings due to the design of the service.

Appropriate training was provided and staff were supervised and supported.

Staff knew the people they were supporting well. Care was provided with kindness and people's privacy and dignity were respected.

There were some activities and entertainment available for people.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to.

People had the opportunity to give their views about the service. There was regular consultation with people and/or family members and their views were used to improve the service. The provider undertook a range of audits to check on the quality of care provided.

Staff and relatives said the management team were approachable. Communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the running of the service.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Not all aspects of the service were safe.

People told us they felt safe however staffing levels were not sufficient to ensure people were looked after in a safe and timely way. Staff were appropriately recruited.

Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

Policies and procedures were in place to ensure people received their medicines in a safe manner.

Is the service effective?

Requires improvement

The service was not always effective.

Staff were supported to carry out their role and they received the training they needed.

Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet to meet their nutritional needs. People who lived with dementia were not encouraged to make choices with regard to their food.

The environment was not all designed to help people who lived with dementia to be aware of their surroundings and to remain involved.

Is the service caring?

Good

The service was caring.

People and their relatives said the staff team were caring and patient as they provided care and support.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

There was a system for people to use if they wanted the support of an advocate. Advocates can represent the views of people who are not able to express their wishes.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs and wishes. People received support in the way they needed because staff had detailed guidance about how to deliver their care.

Summary of findings

There were activities and entertainment available for people.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A relief manager was in place. Staff told us the manager was supportive and could be approached at any time for advice.

People who lived at the home and their relatives told us the atmosphere was good.

The home had a quality assurance programme to check on the quality of care provided.

Orchard Mews

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 August 2015 and was unannounced. The inspection team consisted of an inspector, an expert by experience and a specialist nursing advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people. The specialist advisor helped us to gather evidence about the quality of nursing care provided.

Before the inspection we reviewed the information we held about the service prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send the Care Quality Commission (CQC) within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams. We also contacted health and social care professionals who worked with the service. We received no information of concern from these agencies.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 14 people who lived at Orchard Mews, six relatives, one visiting health care professional, the manager, a registered nurse, eight support workers including one senior support worker, an activities organiser and two members of catering staff. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care plans for seven people, the recruitment, training and induction records for four staff, six people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the manager had completed.

Requires improvement

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. Other people said they felt safe and they could speak to staff. Comments included, "I just press the buzzer and they attend to me," "I like this place," "I'm really well looked after," and, "Staff are around if I need them." A relative commented, The staff are great and hard-working."

We had concerns there were not enough staff to meet people's needs safely and in a timely way.

Our observations and staffing rosters showed there were not enough staff to meet people's needs. The manager told us staffing levels were determined by the number of people using the service and their needs. Our findings did not support that people's dependency levels had been taken into account to ensure sufficient staff over the 24 hour period. At the time of our inspection there were 36 people who lived at the home who were supported by ten staff.

We saw on the ground floor one senior support worker and two support workers were available to provide support to 14 people. This included one support worker providing one to one support for one person at all times. Staff told us two people also required two staff for their moving and assisting needs and five people required total assistance with all their care needs. This meant when the senior support worker was administering medicines and carrying out other senior duties there was only one member of staff available to provide direct care to 13 people.

14 people on the middle floor were supported by one nurse, who was also the deputy manager, and four support workers. Staff told us five people were confined to bed and they required two staff to assist with all their care and support needs. One person also received one to one care at all times during the day because of their behavioural needs. This meant three support workers were available to support 13 people as the other support worker provided one to one support to a person. The nurse was unavailable to provide direct care at all times as they dealt with other duties such as medicines, clinical interventions and liaised with professionals involved in the person's care and ran the home in the manager's absence. Staff told us another person required one to one care because they were at risk of falling. The manager told us this person was waiting for a re-assessment by the commissioners in order to receive one to one support, however, it was not yet in place. We considered action should be taken immediately to keep the person safe as we observed the person on the floor during the inspection. When staff were busy attending to people in their rooms other people had to wait for assistance or were at risk as they were not supervised. A staff member commented, "We could do with more staff on the middle floor, most people need two staff to care for them, one person sometimes needs four staff because of their needs."

Eight people on the top floor were supported by one senior support worker and two support workers. One person also received one to one care at all times during the day because of their care and support needs. This meant one support worker was available to support seven people as the other support worker provided one to one support, the senior support worker was not always available to provide direct care as they had other responsibilities.

This is a breach of Regulation 18 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We saw care plans for distressed behaviour were in place and they provided clear guidance for staff about the actions that should be taken when the person became agitated and distressed. For example, "Triggers-needs for smoking immediately, busy environment, if staff say they will take (Name) they must take them immediately as this will ease their anxiety and aggression." However, due to staffing levels and the different needs of people staff would not have time to take immediate action to take the person for a cigarette to pacify them.

The complaints and safeguarding logs provided evidence of incidents that had taken place when staff members had not been available to provide supervision to people.

The provider had a system in place to log and investigate safeguarding concerns. We viewed the log and found 20 concerns had been logged appropriately. Safeguarding alerts had been raised by the home and investigated and resolved. We saw some of the alerts concerned incidents of aggression by a person who was supposed to receive one to one care at all times. The manager's analysis of the incidents showed they had not been receiving this supervision when some of the incidents of aggression occurred with other people.

Staff had a good understanding of safeguarding and knew how to report any concerns. They were able to describe various types of abuse and were able to tell us how they

Requires improvement

Is the service safe?

would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. They told us they would report any concerns to the manager. Staff members commented, "If I had concerns about any one's safety I'd go straight to the manager or safeguarding," and, "If I saw something suspicious I'd report it to the senior care staff or manager."

People received their medicines in a safe way. We observed medicines rounds on two floors. Medicines were administered by the nurse for people with nursing needs and the senior support worker, who was responsible for administering medicines to people with non-nursing needs. We saw they checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. The staff administering medicines explained to people what medicine they were taking and why. They gave the person a drink with their tablets and then remained with each person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Medicines were given as prescribed and at the correct time. Both staff members told us medicines would be given outside of the normal medicines round time if the medicine was required. For example, for pain relief. We saw there was written guidance for the use of "when required" medicines, and when these should be administered to people who showed signs of agitation and distress. One person's care plan for distressed behaviour stated, "(Name) can get agitated and aggressive especially when suffers from knee pain or constipation, staff continue to follow medicine care plan, incorporating Lorazepam if nothing else works."

All medicines were appropriately stored and secured. Staff were trained in handling medicines and

a process had been put in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for falls, pressure area care and nutrition.

Regular analysis of incidents and accidents took place. The manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. A staff member commented, "We discuss falls at our monthly health and safety meetings." Records showed a person who had fallen more than twice was referred to the falls clinic.

We spoke with members of staff and looked at four personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people. Copies of interview questions and notes were also available to show how each staff member had been appointed.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with promptly. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Requires improvement

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs. They told us they thought training was appropriate although it was mostly on the computer and not face to face. They said they could make suggestions for training. Staff comments included, "All touch (computer) training is up to date," "Very few of the training courses are face to face," "I'd like to receive some face to face training," "I've had mental capacity and best interest touch training," and "I've not had syringe driver training."

We spoke with members of staff who were able to describe their role and responsibilities clearly. Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. One staff member told us, "I had a twelve week induction when I started and shadowed a more experienced member of staff for two days."

The staff training record showed staff were kept up-to-date with safe working practices. The manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Training courses included, dementia care, distressed behaviour, nutrition and hydration, dignity awareness, person centred care, promoting healthy skin and equality and diversity. All support staff had achieved a National Vocational Qualification (NVQ), at level three, now known as the Diploma in Health and Social Care.

Support staff said they received regular supervision from one of the home's management team every two months and nurses received supervision from the manager. Staff member comments included, "The manager does my supervision, we discuss what we need to improve on, concerns and training," "The deputy or manager do my supervision every two months," "The deputy does most supervisions," and, "I definitely think I'm listened to." Staff also received an annual appraisal to evaluate their work performance and to jointly identify any personal development and training needs. A staff member commented, "I have an appraisal annually." This showed staff were supported in their role as well as assisted to identify their individual training needs.

CQC monitors the operation of the Mental Capacity Act (MCA) 2005. This is to make sure that people who do not have mental capacity are looked after in a way that respects their human rights and they are involved in making their own decisions, wherever possible. Staff were aware of and had received training in the MCA and Deprivation of Liberty Safeguards (DoLS). DoLS are part of the MCA. They are safeguards put in place by the MCA to protect people from having their liberty restricted without lawful reason. We checked with the manager that DoLS were only used when it was considered to be in the person's best interests. They were aware of a supreme court judgement that extended the scope of these safeguards. We found as a result, that seven applications were being considered and three people were currently subject to such restrictions.

Records showed assessments had been carried out, where necessary of people's capacity to make particular decisions. For example, with regard to going out unaccompanied.

Staff asked people for permission before delivering any support. They said they would respect the person's right to refuse care. Staff said if a person did refuse they would offer alternatives or leave the person and try again later. For example, if a person refused to receive assistance with personal care.

We checked how people's nutritional needs were met. Care plans were in place that recorded people's food likes and dislikes and any support required to help them eat. For example, a record stated, "Soft moist, support with meals, likes curry and rice and lemon meringue pie, dislikes fish, support with drinking using a straw. Fluid preferences cranberry juice, black currant juice and tea with milk, no sugar." We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned produce. One person said, "The food is okay. You get a choice." We saw food was well presented and looked appetising. People were positive about the food saying they had enough to eat and received nice food. People's comments included, "The chef is very good," "The food is very well cooked," "The food is lovely," "I had two helpings of mashed tatties," "I'll have some fruit as well," and "I have a jam sandwich when I want." Comments from relatives' in a recent survey sent out by the provider

Requires improvement

Is the service effective?

included, "Great food, I have had several meals which were first class," and, "My relative did not eat very well before but they love the food here." Hot and cold drinks were available throughout the day.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised tool Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid balance' charts. However, for one person who was confined to bed, an accurate record was not always maintained to monitor the amount of food and drink the person had taken. Referrals were also made to relevant health care professionals, such as, GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of a person's poor nutritional intake. Staff meeting minutes and menus showed the manager had introduced various initiatives such as milk shakes and smoothies for morning and afternoon drinks to help fortify people and improve their nutrition. Snack boxes were also available in communal areas for people to help themselves. They contained pre-wrapped chocolate bars, biscuits and crisps to help increase the nutrition of people who were at risk of poor nutrition and weight loss.

We saw people who lived with dementia on the top floor were not encouraged to make choices about their food at the lunch time meal. Staff did not show people two plates of food to help them choose what they wanted to eat. One member of staff told us, "People won't understand how to make a choice." Menus were not available in any other format for example, pictures or photographs if people no longer understood the written word. In other dining rooms we saw menus were available and people were offered a choice of food by staff showing people options to help them make a choice such as two plates of food.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. Staff received advice and guidance when needed from specialists such as, the dietician, optician, speech and language teams, behavioural team and GP. Records were kept of visits and any changes and advice was reflected in people's care plans. For example, we saw a care plan was available from the challenging behaviour team to provide guidance to staff for a person who displayed distressed behaviour.

Relatives told us they were kept informed by the staff about their family member's health and the care they received. A relative commented, "I am kept informed of any medical problems. They just ring me."

People's needs were discussed and communicated at staff handover sessions when all staff changed duty, at the beginning and end of each shift. This was so staff were aware of risks and the current state of health and well-being of people. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. A staff member commented, "Communication is very good."

We found some areas of the premises were 'enabling' to promote people's involvement and independence. However, not all areas were enabling to promote people's orientation and involvement. We saw no pictorial aids or orientation aids, such as activity boards, calendars, newspapers and magazines to help remind people of the date and time on the top floor. The communal areas and hallways did not have decorations and pictures of interest, displays or themed areas on the top floor corridor to stimulate people as they sat or walked along the corridors. This meant people were not all helped, by their environment, to remember and be mentally stimulated. The manager told us a programme of decoration was in progress and some areas of the home had been decorated and work was on-going and this would be addressed.

On other floors people were able to identify different areas of the home. There was appropriate signage and doors such as lavatories and bathrooms had pictures and signs for people to identify the room to help maintain their independence. Memory boxes had been completed for some people that contained items and information about people's previous interests and they were available outside some people's rooms to help them identify their room. They also gave staff some insight into the person's previous interests and life when the person could no longer communicate this information themselves.

We recommend the provider considers the National Institute for Health and Care Excellence (NICE) which states, "Health and social care managers should

Requires improvement

Is the service effective?

ensure that built environments are enabling and aid orientation."(NICE, Dementia-Supporting people who live with dementia and their carers in health and social care, November 2006:18)

Good

Is the service caring?

Our findings

People who used the service and relatives we spoke with were positive about the care and support provided. People's comments included, "The staff are good and they have been good to me," "I get on well with staff," "The staff are excellent," "The staff are alright I'm getting by," and, "The staff are lovely. This is a very good place." Relative's comments included, "I come in every week. The staff are lovely to the folk. They are all so friendly," "My relative is happy here. The place is not large and the staff are like family," "The staff are friendly and helpful," "We looked at other homes but I'm very satisfied we chose this one," "The staff are very approachable," and, "The staff are great and hard working."

People were supported by staff who were warm, kind, caring and respectful. They appeared comfortable with the staff who supported them. Good relationships were apparent and people were very relaxed. Minutes from a recent meeting of people who use the service and relatives also commented about people's appreciation of staff. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. For example, when they offered assistance to people as they moved from their seat or when a staff member offered a person a choice of drink.

We saw that care was provided in a flexible way to meet people's individual preferences. For instance, people had the opportunity to have a lie-in. One person's care plan recorded, "Ask (Name) if they'd like to go for breakfast or remain in bed as this is sometimes their preference."

Staff we spoke with understood their role in providing people with effective, caring and compassionate care and support. They were able to give us information about people's needs and preferences which showed they knew people well. For example, one staff member said, "Although (Name) doesn't talk they will say 'lovely' or 'terrible' if we ask them how they feel about something." People's privacy was respected. We saw staff ensured any personal care was discussed discretely with the person. A person's care plan stated, "(Name) has no issues regarding which staff member assists them." Staff treated people with dignity and respect. We saw staff sat with people at meal times to provide assistance to people who needed support. They knocked on people's doors before entering their rooms. We observed that people looked clean and well presented. Most people sat in communal areas but some preferred to stay in their own room.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information and showing two items of clothing so people could choose what they would like to wear. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. For example, written guidance was available in a person's care plan, "(Name) is able to express their likes and dislikes using non-verbal cues by facial expression and body language." People's personal hygiene care plans also included reference to choice to remind staff about involving people in daily decision making. One care plan stated, for example, "(Name) is capable of making choices independently and enjoys choosing which clothes they will wear."

We observed the lunch time meals on all floors of the home. The meal time was relaxed and unhurried. People sat at tables set with tablecloths and condiments. Specialist equipment such as cutlery and plate guards were available to help people. Tables were set for three or four and staff remained in the dining area to provide help and support to people. Some people remained in their bedrooms to eat. Staff provided full assistance or prompts to people to encourage them to eat, and they did this in a quiet, gentle way. Saying for example, "Take your time to eat it and enjoy it," "Do you want anymore," "Can you manage that, "and, "Let me help you."

Important information about people's future care was stored prominently within their care records, for instance where people had made Advance Decisions about their future care. Records looked at, where these were in place, showed the relevant people were involved in these decisions about a person's end of life care choices. The care plan detailed the "do not attempt resuscitation" (DNAR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

Good

Is the service caring?

We were told the service used advocates as required but most people had relatives. Advocates can represent the views for people who are not able to express their wishes. We were told one person had the involvement of an advocate.

Good

Is the service responsive?

Our findings

People confirmed they had a choice about getting involved in activities. However, some people and relatives told us they would like more activities and outings. People's comments included, "More entertainment would be a good thing in here." "More bus trips out would be good," and "I'd like more activities." Some people said they went out either on their own or with staff support. Their comments included, "I go out shopping now and again," "On Saturday night I take a taxi to go and have a game of bingo and a drink." A staff member said, "(Name) goes to aerobics at the local sports centre." A staff survey sent out by the provider in June had received 16 positive comments from 19 sent out about activities. We saw the manager had responded to suggestions and told people, "We will ensure more minibus drivers are recruited to drive the mini bus so we can take more people out into the community."

A weekly activities plan advertised what was available. These included, "dancing, bingo, painting, aerobics, arts and crafts, polishing silver, dominoes, board games, movies and sing-along." The activities person told us regular entertainment took place in the home. A person commented, "I love the singers." We saw the activities person playing Scrabble with three people in the morning and making clay ornaments with the same people in the afternoon, however they remained downstairs during the day and did not provide activities elsewhere. The activities plan showed staff were rostered to provide activities to people as well as the activities organiser. However, current staffing levels would not afford staff time to provide these activities as we observed staff were busy supporting people with other care needs. We saw staff did engage and interact with people whenever they could. A staff member commented, "Staff try to spend as much time as possible with people, if beds aren't made they can be made later."

Detailed information was available to help staff provide care and support when a person was no longer able to tell staff themselves how they wanted to be cared for. People's care records contained information about their life history, likes and dislikes which gave staff some insight into people's previous interests and hobbies when people could no longer communicate this themselves. For example, "During the day I enjoy reading, watching television, socialising with others." Information was also available with regard to their wishes for care when they were physically ill and to record their spiritual wishes or funeral requirements. We saw a special minister from a local church was visiting to give Holy Communion to a person.

Records showed people's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in people's needs. For example, the dietician was asked for advice with regard to nutrition. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording when staff turned a person in bed, where it was identified a person was at risk of developing pressure areas. These records were necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

Regular meetings were held with people who used the service and their relatives. The manager said meetings provided feedback from people about the running of the home. July's meeting minutes showed the discussions about activities and the action taken to improve them. "New programme been introduced and encouraging all carers to become involved. Many day-to-day activities can be meaningful if done in a way that engages and stimulates residents." We saw the meetings were an opportunity for people to give feedback about the care they received. Comments from people included, "Like the current hairdresser. Good advice as well as good styles."

People said they knew how to complain. The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained and we saw five had been received, investigated and resolved.

Good

Is the service well-led?

Our findings

A permanent manager was not in post but they were due to start at the service 26 October 2015. A relief manager was managing the home and had been in position since the previous manager left in April. They had applied to be registered as manager with the CQC in July 2015. The relief manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities.

The relief manager said they had introduced changes to the service to help its smooth running and to help ensure it was well-led for the benefit of people. They responded quickly to address any concerns. For example, meeting minutes for the catering department showed staff had been updated with the progress and increase in weight for some people where there had been concerns about weight loss and loss of appetite. The manager also said they readily accepted any advice and guidance. Minutes from a meeting with people who used the service and relatives showed improvements that had been made, "General agreement that things have really improved," and "Those who weren't happy before are now and have really noticed a difference."

People told us the atmosphere in the home was warm and friendly and relatives said they were always made welcome and they could visit at any time. Staff, people and relatives said they felt well-supported. Comments included, "The manager is very approachable," "The manager is brilliant, not a bad word to say about them," "Really nice place to work, staff get on really well," "(Name), the manager is wonderful, they're approachable, and pulling the home together," and "Wish they were staying."

Records showed audits were carried out regularly and updated as required. Monthly audits included checks on, documentation, medicines management and nutrition. Three monthly audits were carried out for health and safety, falls and infection control. The manager told us monthly visits were carried out by the area manager to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans and staff files. A three monthly audit was also carried out by a representative from head office. These were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. A financial audit was carried out by a representative from head office annually.

Staff told us regular staff meetings took place and these included nurses and senior meetings and general staff meetings. Staff meetings kept staff updated with any changes in the home and to discuss any issues. Minutes showed meetings had discussed communication, meal time experience for people, staff training, refurbishment and moving and assisting equipment. Staff members told us meeting minutes were made available for staff who were unable to attend meetings. A staff member commented, "Separate meetings for day and night staff, manager attends both." We observed a short daily, 'flash' meeting which we were told took place with a staff representative from each department to keep staff up to date about any issues or areas that required urgent action during the day. Items discussed included, housekeeping, people's care and nursing needs, catering, activities and administration.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out monthly to staff and annually to people who used the service. Surveys had been completed by people who used the service in 2014. Findings from the survey were positive.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staffing levels were not sufficient to look after people in a safe, timely and respectful way.** Regulation 18(1)